DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ______________

Former Dentist ______________________ Date of last dental X-rays ______________

Address ______________________________ Has Address Changed? ❑ Yes ❑ No

Check (✓) if you have had problems with any of the following:

❑ Bad Breath	❑ Grinding teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between the teeth	❑ sensitivity to cold	❑ sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Have you had any serious illnesses? ❑ Yes ❑ No If yes, describe ______________________

Have you had any operations? ❑ Yes ❑ No If yes, describe ______________________

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, approximate dates ______________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No On birth control? ❑ Yes ❑ No

Do you smoke/use spit tobacco? ❑ Yes ❑ No Amount per day ______________________

Check (✓) if you have or have had any of the following:

❑ Anemia	❑ Congenital Heart Lesions	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cortisone Treatments	❑ Hernia Repair	❑ Shortness of Breath
❑ Artificial Heart Valves, Type______________		❑ Cough, Persistent	❑ High Blood Pressure
❑ Artificial Joints, Pins etc., Year_____	❑ Skin Rash	❑ Cough up Blood	❑ HIV/AIDS
❑ Stroke	❑ Asthma	❑ Diabetes	❑ Jaw Pain
❑ Swelling of Feet or Ankles	❑ Back Problems	❑ Epilepsy	❑ Kidney Disease
❑ Thyroid Problems	❑ Bleeding Abnormally	❑ Fainting	❑ Liver Disease
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tonsillitis
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tuberculosis
❑ Chemical Dependency	❑ Radiation Treatment	❑ Ulcer	❑ Chemotherapy
❑ Heart Problems	❑ Respiratory Disease	❑ Venereal Disease	❑ Circulatory Problems
❑ Hemophilia	❑ Rheumatic Fever		

List medications you are currently taking and the correlating diagnosis: Allergies:

______________________ ______________________

______________________ ______________________

______________________ ______________________

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.